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Abstract

The link among health, well-being and social support is well known. Social support represents an important protective factor against stress both directly (see the main effect hypothesis) and as a mediator (see the stress-buffering hypothesis; Beckman & Syme, 1979; Cohen, 2003). Nevertheless, it fosters health but at the same time may create a burden for those who work as caregivers and perceive the strain of their professional responsibility. Moreover, the relationship between health and social support implies the consideration of gender differences and gender roles. Indeed, in most societies women more often than men offer support, as mothers, daughters, wives, but also in voluntarism and social participation.
Therefore, if health is a common good and social support contributes to this phenomenon, it is important to identify processes and mechanisms that favor the development of social networks to functional well-being and to analyze the social conditions that may improve the health status of groups and people. Basic questions should be considered: how do people consider health? Which factors can promote it and what are the causes of disease in the mind of caregivers? How do male and female caregivers consider the health needs referred both to persons to help and to themselves?
This contribution presents some theoretical consideration about health and social support from a gender perspective. Then a qualitative research is described. The study involved 35 volunteers in the health domain (51.43% men) who were interviewed about the meaning of health and illness and being in health/illness. Data are presented in order to describe gender differences in the representation of health and illness and to investigate the role social support, both received and given, plays in this representation.

Representations and actions. A lay perspective around health

The biomedical approach regards illness in terms of physical symptoms and of the underlying physical pathology. Nonetheless, to the lay person illness is a much more complex process (Marks, Murray, Evans, & Estacio, 2015).

One of the most widespread psychosocial approaches aimed at understanding illness representations stems from social representations theory (Moscovici, 1961). As Marks and colleagues (2015) underline, "social representations are concerned with the socio-cultural understanding of the phenomenon that is revealed not only in language but in everyday social practices. Social representations theory is concerned with both the content of these representations and how they operate to shape our engagement with the world" (Marks et al., 2015, p. 398). Since the early work conducted by Herzlich in 1969, a high number of studies have analyzed the social representation of illness (Flick, 2000; Flick, Fischer, Schwartz, & Walter, 2002; Howard, Foster, & Dorrer, 2004; Jodelet, 1989; Markova & Farr 1995). According to this approach, "health is a highly social, emotive, and symbolic entity" (Joffe, 2002, p. 560), and its representation encompasses meanings that "contain emotional and political, rather than purely cognitive, elements". Furthermore, social representations participate in constructing a consensual view and guide individual and collective behaviours. In this regard, practices can also contribute to the construction of a social representation: an action is a process that can modify representations. Besides, different social insertions may lead to different social representations (Abric, 1994; Jodelet, 1989). As Jodelet argued (1989), representations are based on values that vary in accordance with social groups – from which they draw their meaning – and on previous knowledge reactivated by a particular social situation. Representations are connected to wide ways of thinking, ideological or cultural, to the state of scientific knowledge, as well as to social condition and to personal and affective experience. These representations give rise to spontaneous "theories", to versions of reality that embody images or summarise words, both meaningful. Through these different meanings, representations express those who forge them, and give a specific definition of the object represented. These definitions, shared by the members of the same group, build up a consensual view of reality in the group.

Therefore, since social representations differ according to the diverse positions of individuals in the social context, and individuals, on the basis of the category to which they belong, are object and subject of stereotyped evaluations, we can expect different representations of health and illness in men and women.

These differences are the result of gender stereotypes (self- and hetero-attributed), according to which different reactions and behaviors are expected in men and women, and in line with these expectations, men and women actually behave differently. As for the topic of health and illness, we are referring to the fact that women are expected to play a more active role in caring than men and that women act accordingly, while a man engaged in caring practices is regarded as "an exception that proves the rule".

Moreover, taking into account the circular relationship between social practices and social representations, one cannot disregard the maintenance function that these social representations have in preserving differentiated roles, culturally ascribed to gender differences (Howard et al., 2004), an aspect also related to the role that social representations of health fulfills in the construction of identity and social recognition (Markova, 2003; Markova & Farr, 1995). In addition, many gender theorists suggest that health care practices are gendered, so that "doing" health reflects "doing gender" (Courtenay, 2000; Noone & Stephens 2008; Saltonstall, 1993; West & Zimmerman, 1987).

These premises given, we will provide a number of reflections on the topic: health from a gender perspective.

Health from a gender perspective

Nowadays it is recognized that women's and men's health differ as a consequence of biological factors. However, also imbalances in roles, social structure and cultural conventions produce inequality in health (Levy, Chemerynsky, & Tuchmann., 2006; MacIntyre, Hunt, & Sweeting, 1996). Therefore, the biological dimension is not sufficient to explain health dissimilarities (De Piccoli & Rollero, 2015; Rollero, Gattino, & De Piccoli, 2014).

After examining thousands of studies conducted in various countries, the American Medical Association stated that being a man or a woman has relevant implications for health and, more specifically, it conditions immune responses, symptoms, the type and mode of occurrence of cardiovascular diseases, reaction to pathogens, brain organization, and tolerance to pain (Wizemann & Pardue, 2001).

For several decades, health differences between men and women have been considered merely sexual, and therefore in relation to specific diseases (such as obstetric problems and cervical cancer versus prostate cancer). Recently, however, there has been increasing interest in the relationship between sex, gender and health. This interest has been manifested in considering gender as a social construction (Doyal & Naidoo, 2010). Research conducted under this perspective permitted to increase substantially knowledge and understanding of the complex relationship between gender and health, which can be summarized by stating that women live longer however worse than men. The next question, therefore, pertains to the reasons of these outcomes, that's to say, what interpretations can be given to explain why gender usually affects length and quality of life? The answers are numerous, not necessarily mutually exclusive, in fact, they are often complementary, and connected to the interweaving of biological, socio-structural, psychosocial and behavioural aspects.

To analyze the factors affecting health according to a gender perspective it is necessary to addrees it from a multi-dimensional perspective (Bekker, 2003; De Piccoli & Rollero, 2015; Rollero, 2014). Among the different models, the one proposed by Bekker (2003) seems to us offering a greater integrated perspective.

This model, called *Multi-facet Gender and Health Model*, first considers the influence of the body, therefore the biological sex an individual belongs to, which directly affects health in gender-specific way. Sex also affects gender, meant as a sociocultural construction, since men and women are attributed characteristics and stereotypes of "male" and "female." The relationship between body, gender and health can be mediated by three factors. The first refers to the different social position of men and women: profession, the number of paid working hours, the amount of free time and time spent on unpaid work, as well as the time spent in care of children or other persons. The impact of all this on health has been widely reported in many empirical studies. Stress experienced by women for domestic work or extra-familial commitments, for example, decreases their quality of life (Lundberg & Frankenhaeuser, 1999; De Piccoli & Rollero, 2010), nonetheless sometimes the reconciliation of different roles, such as business and family, increases the satisfaction with their lives and the level of well-being (Hibbard & Pope, 1991).

The second group of mediators includes differences in personal characteristics, determined by gender membership, relevant to health. Specifically, the model includes here somatic, psychological, cognitive and behavioral aspects, such as attitudes towards the body, coping strategies, personality traits, and mood states. Body dissatisfaction, for example, is much more common in women and is one of the main predictors of the development of eating disorders and other damaging consequences (Moradi & Huang, 2008; Rollero, 2013; Rollero, 2015).

Finally, the last category which intervenes in the relationship between sex, gender and health comprises diagnostic and therapeutic procedures. They, too, are influenced by the gender of the person turning to a professional for health problem. In particular, several studies have shown that gender stereotypes induce specific expectations in the doctor-patient interaction (Ong, de Haes, Hoos, & Lammes, 1995). When they turn to a consultant, women tend to speak more of their life in general, while men remain centered on the health problem they want to address. Research on physicians has shown, however, that, for the same clinical condition, male doctors prescribe sedatives (specifically benzodiazepines) more often to women than to men (van der Waals, Mohrs, & Foets, 1993).

The *Multi-facet Gender and Health Model* has the merit to highlight that differences in health and well-being among genders, in addition to intra- gender differences, cannot be explained by a single type of factors. However, gaps still must be filled. Primarily, a deeper and psychologically oriented analysis of the fundamental elements of the model ought to be performed. For example, as for

personal factors, Bekker does not specify what the most relevant are, since the wealth of research that has already investigated the role of these factors on health is not taken into account.

Denton, Prus and Walters (2004) assert that structural and psychosocial factors are more significant to explain women's health, while behavioral factors are more significant for men. Besides, different social and family gender roles, lifestyles and preventive *practices* may affect vulnerability to illness in both men and women (Arber & Cooper, 1999; Garcia-Calvente et al., 2012).

A qualitative study by Garcia-Calvente et al. (2012) shows that "among women, the main topic in relation to their health was exhaustion, mainly accounted for by referring to socially-acquired roles. Women give health a meaning of personal balance, which they consider to have lost as a result of the excessive burden of what are still considered to be women's responsibilities (care of the home and the family). (…) the way women socialize makes it easier for them to talk about themselves, to answer questions on their health and express their complaints, which may suggest they are more prepared to talk openly about a worse state of health (p. 920)". "(…) In contrast, our results show that men tended to overrate their health, basing on the 'tough men' stereotype associated with the masculine image. Other studies also point out that it is difficult for a man to recognize and express his needs, feelings, and emotions as this is considered to be a sign of weakness and feminization" (p. 921).

From a psychosocial perspective, among the different patterns of differences between men and women in the health domain, we focus our analysis on the different actions men and women are involved in when they cope with illness, when the disease affects themselves or others (family members, friends) or when they decide to volunteer helping sick people.

An empirical study on social representations of health and illness

The present study aims at investigating social representations of health and illness, with a specific interest in analysing differences between women and men.

We contacted 40 people volunteering in the Turin area (Northern Italy) in four organizations (Cittadinanza Attiva – Active Citizenship; AVO – Association of Hospital Volunteers; AVIS – Association of blood donors – and Croce Verde – Green Cross), and we administered a semi-structured interview aimed at investigating social representations of health and illness. Data from 35 respondents are shown here (5 interviews were not used). Among participants, 18 were men and 17 women. Their mean age was 65.09 (*SD* = 7.04, age range: 52-75).

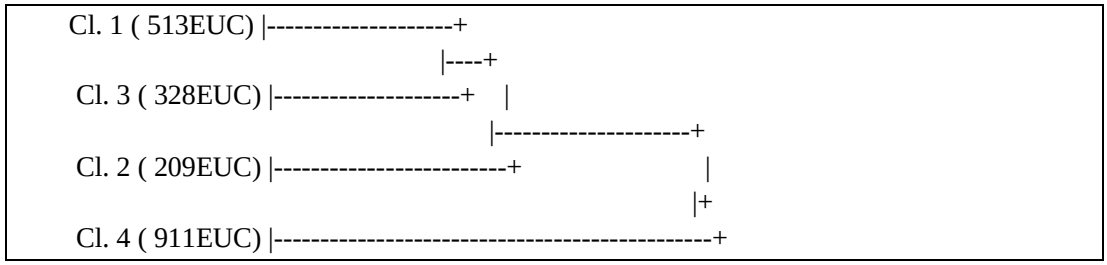
Questions aimed at exploring semantic content related to the concepts of health and illness, also expressed through metaphors, images, reference to significant others for the respondent, behaviours and social practices considered meaningful, and the communication processes involved. We performed joint analyses of all fully transcribed answers (the textual corpus) of 35 interviews.

We performed textual data analyses with the Alceste software package (Reinert 1987; 1993), a computer-based application, widely used in social sciences, that combines textual and statistical analyses. It performs a descending hierarchical cluster analysis based on text fragments that are labelled elementary unitis of context (EUC); it is an iterative procedure. The result is a hierarchy of classes, which can be represented in a tree diagram (dendrogram). The resulting Alceste classes reveal underlying representations or concepts which are lexicalized through a set of related clusters and a characteristic vocabulary. Moreover, through the χ^2 test, the software compares the within-cluster occurrence of the words with their overall occurrence on the total of responses: the highest χ^2 values correspond to the most typical words of that cluster. Thus, the researcher obtains a list of the most characteristic words for each class, along with their χ^2 statistical significance (with the minimum χ^2 value for selection set at 2.13, below which the level of statistical significance fails to reach the 10% level, using the standard χ^2 table with 1 degree of freedom). Finally, by means of the same statistical analysis, this software consents to test the association between clusters and selected characteristics of participants (considered as categorical variables). In the present study, we selected gender. The gender dimension did not enter in the creation of the dendrogram but, once the analysis was made, Alceste detected whether this descriptive variable was typical of each cluster.

The dendrogram relative to the Descending Hierarchical Cluster Analysis showing the organization of the semantic areas is presented here:

Cluster 1 represents 26.16% of text: *informal cures in case of illness*
Cluster 2 represents 10.66%. of text: *technical-scientific aspects of medicine*
Cluster 3 represents 16.73%: of text: *illness and its somatic implications*
Cluster 4 represents 46.46%: of text: *health, illness and quality of life*

Fig.1. Dendrogram of classes



Health and illness representations: gender differences

Cluster analysis shows that it is possible to identify different representational universes, referred to both health and illness, according to gender.

The dendrogram indicates that the first partition is the one between the typical masculine universe class (cluster 4) and the other three: cluster 2, which does not show gender differentiation, and subsequently, clusters 1 and 3 that are typical of the feminine universe.

Table 1 shows the words typically connected to clusters and the variables that characterize them.

In general, clusters show that women express more specific semantic universes about illness (cluster 1 and cluster 3), while men refer to a complex frame in which both health and illness are involved.

In particular, cluster 1 refers to what might be called informal care in case of illness since it relates to informal relationships, especially with family members, who perceive the interviewee as an "actor of care to be provided to others". Such care requires time to "be made available" and a place, essentially identified with home. A number of statements significantly related to the cluster exemplify these semantic universes. Time evoked is time that entails hard work and sacrifice:

"At night my **mother** used to phone me: 'Run'. I do not know how many times I spent my **nights** there, I spent **nights** and **days**, then I just said, I, too, need to have a life, and then I found the caregivers, first only during the **day** and then at **night** too, although I was there **every day**".

"One of my **grandchildren** told me: If you want to see your **brother** alive come on down. Oh, and I, in a jiffy, I was painting, you think, in two hours I had to take the train and go down".

Table 1. The different semantic universes

Cluster 1		**Cluster 3**		**Cluster 4**		**Cluster 2**	
Informal cures in case of illness		***Illness and its somatic implications***		***Health, illness and quality of life***		***Technical-scientific aspects of medicine***	
sons home to go	107.1	Years to	150.42	Health	71.45	physician Internet	419.15
days lady to live	1	begin	67.43	illness	71.16	basis informations	246.75
husband	83.89	operation	52.15	physique	70.64	consultant council	120.32
grandchildren	70.65	back	48.18	life	70.02	health structure	117.90
grandparents	69.52	luck mom	46.13	people	60.77	to turn to health	101.21
children	62.64	dad	44.15	healthy	36.79	services	68.30
brothers hours	57.74	appendic it	41.79	alimentatio	28.00	users examination	66.45
to marry board	55.29	is	39.99	n wellbeing	26.82	encyclopedia private	66.45
must	41.00	tumor month	36.81	mind	25.28	computer to use	58.89
	34.21	sudden to	36.03	society can	24.47		58.11
***women**	33.47	fall	34.98	situation	23.74		57.17
	32.70	down stroke	28.34	sport	22.18		50.45
	31.42	head knee	24.91	factors to	22.11		50.45
	27.51		22.86	try	22.11		49.81
	24.98	***women**	15.09		20.99		42.13
	13.97			***men**			
			6.65		**119.88**		
	99.71						

“She had Alzheimer’s, my **brothers** had her in their **house** and I came every day and then when she could no longer stand I took her to my **house**”.

Cluster 3, connected to cluster 1 (as shown by the dendrogram) refers instead to *illness and somatic implications*, explicitly calling both the parts of the body affected by the disease and the diagnostic and therapeutic interventions. The focus is here on the physical illness that has hit them or close family members and that often represents a painful experience for interviewees, evoked through salient memories.

“... She had three **angioplasties**, two by-passes and so on. Instead, **Dad** had a **stroke**, he was 65 and paralyzed, completely nailed to a wheelchair and then two years later he died; these were the ugliest events”.

“We were four **sisters**, unfortunately the oldest passed away at 59 for breast cancer and with this familiarity ...”

“My worst disease was in my **knee**, in addition to the **fracture** of the **frontal lobe**, but then I was in a coma so I don’t remember, then there was the breaking of my **arm**, and then my **knee** ... I was up to all sorts of things...”.

Both these clusters refer to a relational way of dealing with illness unavoidable for the female universe; a process of care that also involves networks of proximity and social capital.

Cluster 4, the most relevant in terms of “analyzed context units” (46% of the textual material under analysis belongs to this cluster) identifies the representation expressed by men, weaving together the themes of health and illness, however with a focus on health and on the factors that may affect good quality of life, both from the physical and the psychological point of view. Unlike the first cluster, here the focus is on power, that is on what one can do to keep healthy. Thus, here emerges the possibility for men to express their potentials and resources, even beyond that universe of duty that seems to be a priority for women, essentially a duty “to the other”, rather than to oneself.

“... It is certainly affected by **lifestyle**, **nutrition**. Oh well, it is also a bit a genetic matter, but we **cannot** do anything on that, and then also prevention is for me a rather useful”.

“The word health comes to my mind now as the **balance** that a person has, that they possess in various areas: social, physical, psychic, I think of it much as a balance, this is it”.

“You must have a kind of **healthy life**, to avoid over**eating** or **bad habits** – such as **alcohol**, **smoking**, a number of **factors** that **may** be harmful in themselves, to harm ourselves by an un**healthy lifestyle**, there it is”.

Cluster 2 expresses remarks on medicine, especially by detecting its technical and scientific aspects. In particular, interviewees talk of the informative and therapeutic references they have: who or what they turn to for information, diagnosis or treatment. We therefore found reference to physicians and consultants, within the dialectic between public and private services. The internet, computers and the encyclopedias are referred to as useful tools, although often deemed problematic, and therefore to be avoided or supplemented with professionals’ knowledge. As for this cluster, no gender differences are recorded.

“As I definitely prefer **state** to **private** school, so I prefer the **national health** service...”

"For **health information** I always, and in any case, turn to a physician, I once tried the internet, it explained things but then I asked myself: what would this mean?"

"The relationship with your **GP** is important, they act like a bridge, and they are the people who take **the user** by the arm into the **services**... But, then, you don't usually find people like those, not really".

Conclusion

The study presented in this paper aimed at analysing social representations of health and illness, examining differences between women and men. It involved individuals active in health voluntary organizations, equally distributed between men and women. Results show that a certain number of representations, namely those highlighting technical and scientific aspects of illness, are shared by men and women, while others are gender-specific. Data show that women's perception of health deeply involves the theme of emotional and informal care. As various authors (Del Rio-Lozano et al., 2013; Tobio, 2012) state, women are likely to perceive caregiving as emotional work and this represents one of the utmost significant factors perpetuating the current system of care.

In particular, men express a representation of health and illness in which prevention and lifestyle play an important role, highlighting that individuals can control their own behaviours, obviously here above all meant as healthy lifestyles, while women express an idea of health/illness as events that affect their daily routine, when days are marked by the need of care to be handed out to their family and also, it is a duty to assist those who need care. To sum up, not only women are expected to play the role of caregivers, but women themselves believe they have to play this role.

All this considered, this study presents a number of limitations and suggests future directions. First, the age of our participants, who were all over fifty years old: it would be useful to collect data from younger subjects, in order to strengthen the present results. Secondly, our data were collected in Italy, where gender differences and gender gap are stronger and wider than in other Western countries (Tartaglia & Rollero, 2015; UNDP, 2007). Replicating this research in more gender-equal countries could contribute to extend our knowledge in this field. Finally, another issue that deserves attention pertains to the link between caregivers and the welfare system. Indeed, the caregiver's burden can also be due to the weakness of healthcare and social structures.

As for implications, it seems necessary to pay special attention to the development of efficient and effective home care services, in order to ensure a better quality of life of both patients and their caregivers. All this in the light of the increase in life expectancy and incidence of chronic diseases. Furthermore, considering the gender dimension emerged in this research, it is necessary to work and reduce gender stereotypes, in order to promote a more balanced partition of both the physical and psychological burden resulting from care activities between men and women.

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